

# DPC Summit Pre-Conference

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# The Primary Care Innovators Network (PCIN)

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Strengthening Primary Care to Improve the Health of America

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July 13, 2018

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IEALTH

# **The Power and Impact of Primary Care to Deliver Outcomes That Matter to Patients, Practices and Employers**

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Family Medicine for America's Health  
Employer Advantage Healthcare Solutions  
Family Medicine Education Consortium

# What is the PCIN?

- The Primary Care Network (PCIN) works with self-insured organizations (non-profit, for-profit and public), and the primary care practices serving their employees, to:
  - Enable self-insured employers to improve the health of their employees by building systems and supports needed to provide enhanced primary care solutions to them.
  - Ensure that primary care practices working with those employees are compensated for the value they provide through comprehensive primary care payment

# Who is part of the PCIN?

Family Medicine Education Consortium (FMEC)



Primary Care  
Innovators  
Network (PCIN)

Family Medicine for America's Health  
(FMAHealth)

Employer Advantage Health Care  
Solutions (EAHCS)

# What each member of the PCIN provides

## FMEC

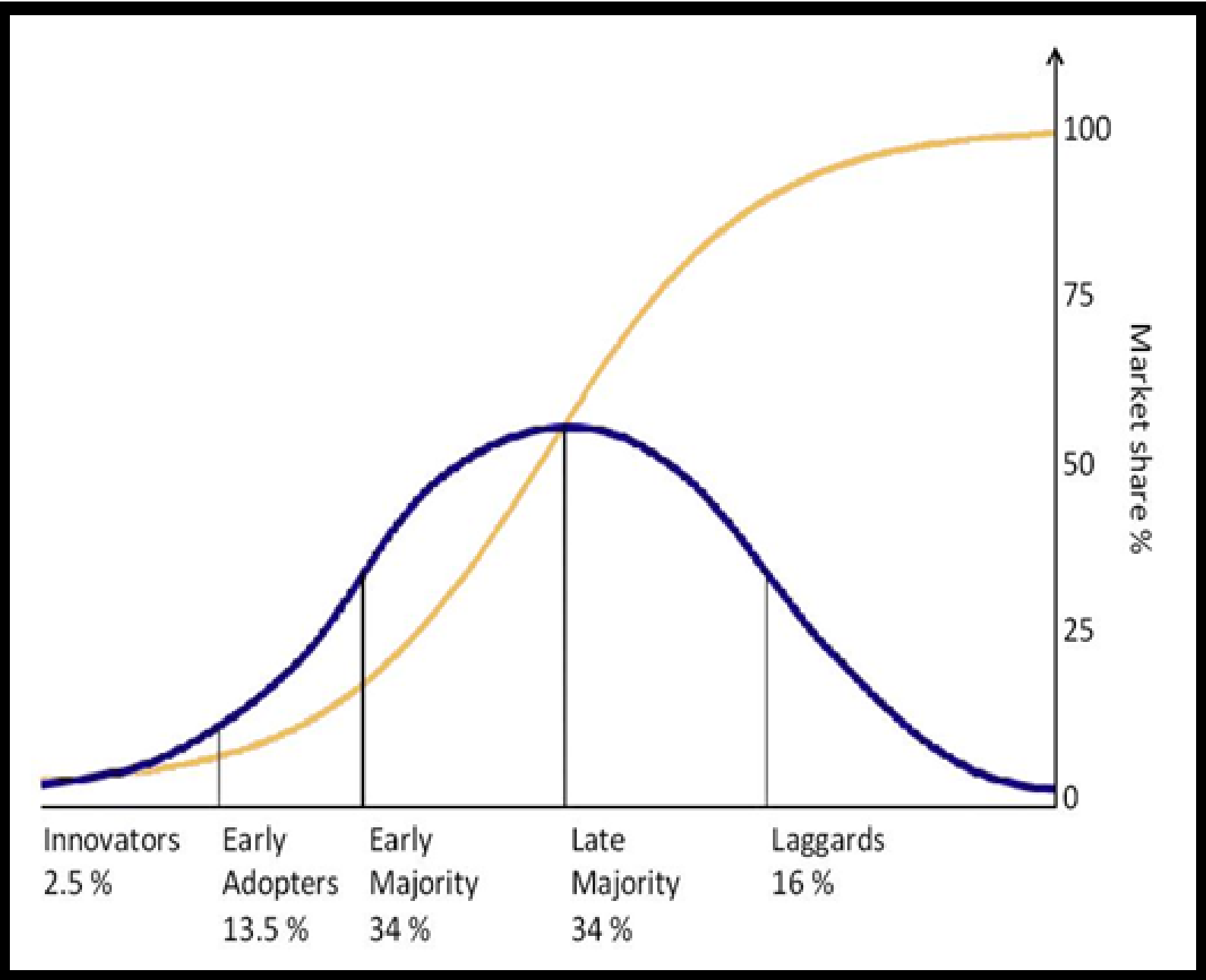
- Brings access to family physicians and their practices around the country along with tools and methods designed to help physicians and employers make the transition to comprehensive primary care payment (one of which is through direct primary care).

## FMAHealth

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## EAHCS

- Brings services and programs that help self-insured employers reduce spending on healthcare while improving the health of their employees—using a direct primary care payment framework.





# Seven Healthy Habits of Advanced Primary Care

Getting the most out of your primary care  
dollars through comprehensive payment  
models

Michael Tuggy, MD  
Vice Chair – Family Medicine for America's Health



# Take this home...

- Comprehensive payment for primary care services encourages high-value care delivery
- Purchasing primary care independently frees practices to serve their patients untethered to higher cost secondary care and billing costs.
- Describe what comprehensive primary care is and what it should deliver

## What we'll discover:

- Learn about how comprehensive primary care payment allows practices to innovate
- Understand how payers and practices can align incentives for better care at a lower cost.
- There are 7 Habits to look for in high value practices

# So what is Comprehensive Primary Care?

- Broad spectrum of care delivery that include direct management of common and complex medical conditions including routine outpatient procedures.
- Includes both acute and chronic care management
- Population health, behavioral health staffing and coordination of specialty care
- Accountable for primary care access

# So, what has to change?

- Current Fee for Service (FFS) payment model does nothing to incentivize this kind of care
- Typical insurance based reimbursement model provide 4-7 % of the total cost of care to primary care services
- This results in an under supported, strained, and partially effective primary care system.

# How does payment affect the way we practice?

- FFS INCENTIVES

- Survival by throughput
- Visit totals are the measure
- “Doing things” to patients – procedures, radiology, labs- to improve reimbursement
- Only face to face encounters count
- Outcomes don't matter (for payment)
- Not responsible outside of office visit

– Reactive Care

# Comprehensive Primary Care Payment (CPCP)

- CPCP INCENTIVES

- Total population that is under care matters most – everyone matters!
- Patient contact (in any form) are allowed by team
- Alternative visits encouraged (email, phone)
- Patient experience matters (i.e. poor service= they leave or get sicker)
- 24/7 accountability
- Outcomes do matter – significantly affects payment

– Proactive Care

# Our Scandinavian Neighbors

- High value and emphasis on primary care
- 40%-50% of physicians are family physicians
- Greater proportion of healthcare dollar invested in primary care (10-12 % of Total Cost of Care)
  - Primary care clinic MD's supported by ARNP's, nursing and support staff focused on their assigned population
- Results:
  - 40-50% lower cost of care on a per capita basis
  - Better outcomes
  - Less reliance on specialty care for truly primary care issues.
  - Universal access to health care

# Direct Primary Care – The US Game Changer

- Investment in primary care yielding cost savings (10-15% TCC goes to primary care)
- DPC population health costs drop dramatically (15-30%) from previous FFS expense models
- Growing number of practices, employer's bargaining for new wrap-around insurance products so they can cover DPC costs.
- Common Denominator – increased time for FTF visits (30 min+ appointments), alternative visits are common.



# CPCP Calculator

Conceptual Framework – (10-12% of Total Cost of Care)

- Pay for Population
  - Case mix risk (HCC), education/income adjusted
- Pay for Quality
  - Achieve optimized quality metrics (outcomes, not data points)
- Pay for Access and Utilization
  - Patient experience
  - Referral and advanced imaging stewardship
  - Scope of procedures
- Pay for Infrastructure
  - Covering core team work and salaries, incentives

# Value Add-ons

- Embedded behavioral health
  - critical to cost savings
- Pharmacist support to manage medication refills
- Physical trainers or physical therapists
- Each of these services can be added on to the base comprehensive payment if the practice has the space to host them.

So what are the 7 habits of a  
high value primary care  
practice?

# Habit #1 – Advanced Access Scheduling

- 30-50 % of visits in a given day are same day appointments
- Simple scheduling templates – no matter what the patient needs, it can be worked into the schedule.
- Longer appointments – 30 minutes for most patients, 60 minutes for intake of new patients
- Quick visits (15 min) – single problem, more acute appointments.
- Alternative visits (phone/Skype visits)

# Habit #2 – Asynchronous Access

- Confidential messaging system tied to the medical record
- Response by team within 24 hours
- Management of chronic disease through electronic messaging
- After-hours urgent care call line
- Quick-hitter questions answered and care completed in 48 hours.
- Value placed on E-visits for provider compensation

# Habit #3 – Care Coordination for Transitions of Care

- Electronic Health Record notifies practice of patients seen in ED or hospital
- Care team has a systemic way of following up from hospital or ED discharges with the patient
- Hand-off of care from inpatient to outpatient sector managed by care management nurses

# Habit #4 – Proactive Preventative Services

- Electronic Health Record tracks and records preventative services
- Care team has a systemic way of reaching out to patients due for preventative services
- Pre-visit preparation process to capture preventative services that are due at a visit
- Vaccine tracking and open access vaccine appointments with nursing staff

# Habit #5 – Cost-Saving Primary Care Procedures

- Some or all of the providers trained to perform common outpatient procedures:
  - Skin biopsy
  - Skin cancer excision
  - Cryotherapy
  - Joint Injection
  - IUD/Implantable contraception
  - Ultrasound
- Reduced referrals with every procedure done



# Habit #6 – Robust Chronic Disease Management Skills

- Physicians able to manage most patients without consultation for:
  - Type 2 diabetes
  - Hypertension
  - Stable ASCVD
  - Congestive Heart Failure
  - Chronic pain
- On-site Care Management Nurses are part of the care team

# Habit #7 – Population Health Management

- Electronic reporting systems in place to track population data for specific high risk disease
- Care teams have regularly schedule population health time to plan and execute on patient outreach
- Quality improvement structure to assess and improve practice outcomes

# The 7 Habits:

- Advanced Access
- Asynchronous Access
- Transitional Care Coordination
- Proactive Prevention
- Robust Procedural Scope
- Chronic Disease Management
- Population Health

# Summary

- As a payer, there are ways to assess how well a practice can take on your population and if they will lower their cost of care.
- Comprehensive primary care payment is the optimal way to fund primary care (at a 10-12 % level of TCC at minimum)
- CPCP aligns the incentives with the work that is of highest value to patients, payers and providers.
- Value equation is impacted by scope of practice and payment should be adjusted to match the scope.



Questions?